

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

Independent Bill Review Final Determination Upheld

6/27/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000442	Date of Injury:	9/26/2012
Claim Number:	[REDACTED]	Application Received:	9/6/2013
Claims Administrator:	[REDACTED]		
	[REDACTED] – 5/19/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	23700, 29805, 20610 and 29820		

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/11/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Other: OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative Version 19.1 (4/1/2013-6/30/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 5/19/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29823, CPT 29820 Modifier 51, CPT 23120, CPT 29826 Modifier 51, CPT 29805 Modifier 51, CPT 23700 Modifier 51 and 20610. The Provider was reimbursed \$5,347.57 and is requesting additional reimbursement of \$3,070.52. The Claims Administrator bundled all of the services on one line with the service description as Facility Charges and reimbursed 5,347.57 with the explanation "Charge for a separate procedure that does not meet the criteria for separate payment. See the OMFS General Instructions for separate procedure rule."

- **CPT 29823:** Arthroscopy, shoulder, surgical; debridement, extensive.
- **CPT 29820:** Arthroscopy, shoulder, surgical; synovectomy, partial
- **CPT 23120:** Claviculectomy; partial
- **CPT 29826:** Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure).
- **CPT 29805:** Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure).
- **CPT 23700:** Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
- **CPT 20610:** Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa).
- **Modifier 59:** Distinct Procedural Service
- **Modifier 51:** Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Per the Provider's appeal letter to the Claims Administrator, the Provider is disputing the "nonpayment of secondary codes: 29820; 29805; 23700 and 20610." The Independent Bill Review application indicated the dispute was regarding "bundled codes, no EOB breakdown provided."

Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The surgical CPT codes 29823, 23700, 29820, 29805, 29826 and 23120 all have an assigned indicator of "T". The "T" indicator

definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. All other services billed are considered costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. These costs include but are not limited to: Anesthesia, medical and surgical supplies and equipment.

The billed CPT code 29805 is a diagnostic arthroscopic procedure. The CPT code 29823, 29820, and 29826 are surgical arthroscopic procedures. When both a diagnostic and surgical arthroscopy is performed, the diagnostic arthroscopy is an inclusive component of the surgical arthroscopy and would not be reported separately. The billed CPT 29805 is included in or cannot be reported with CPT codes 29823, 29820 or 29826.

The billed procedure code 23700 is not generally reported with procedure codes: 29823, 29803, or 29826. All services necessary to complete a procedure based upon standard medical/surgical practice are included in the procedure. Many procedures that are typically necessary to complete a more comprehensive procedure have been assigned independent CPT codes because they may be performed independently in other settings. The service described by CPT code 23700 is typically included when performing the procedure described by CPT codes: 29823, 29820 and 29826 and is therefore bundled into CPT codes: 29823, 29820 and 29826. The arthroscopic procedures include the manipulation under anesthesia procedure (23700).

The procedure code 20610 is included in the global service package of the primary or comprehensive surgical code (29823). The CPT 20610 should not be reported when performed concurrently with another intraarticular procedure (eg Shoulder arthroscopy). The operative report did not report another anatomical site other than the right shoulder; therefore, reimbursement of CPT 20610 is not separately reimbursable when billed with 29823 when performed in the same surgical site and encounter.

Some procedures can be performed at varying levels of complexity. The CPT codes corresponding to more extensive procedures always include the CPT codes corresponding to less complex procedures. The CPT code 29823 is the more extensive procedure that includes 29820. Accordingly, only the more extensive procedures, CPT code 29823, should be reimbursed. The CPT code 29820 is bundled into CPT code 29823.

Based on a review of the Original Medical Fee Schedule (OMFS) Outpatient Hospital Schedule, PPO contract and the Claims Administrator's explanation of review (EOR), the reimbursement of \$5,347.57 was correct. The reimbursement included allowances for the following billed procedure codes: 23120, 29823 and 29826.

Additional reimbursement is not recommended for the billed Ambulatory Surgical Center services for date of service 5/19/2013. The surgical procedures 29805, 23700, 20610 and 29820 do not warrant reimbursement.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ASC services	1	\$3,070.52	\$5,347.57	\$5,347.57	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, explanation of review (EOR) and comparison with OMFS Outpatient Hospital and Ambulatory Surgical Center Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$5,347.57 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

██████████, RHIT

Copy to:

██████████
████████████████████
████████████████████

Copy to:

██
██
██